NC Health Choice: Frequently Asked Questions for Outpatient Mental Health Providers March 2008

GENERAL INFORMATION

1. *What is NC Health Choice for Children?*

It is a fee-for-service health insurance program that provides free or low-cost coverage to uninsured children ages 6 through 18 whose families cannot afford private health insurance and who do not qualify for Health Check (the Medicaid program for children). The program was established in 1998 by the federal government and the State of North Carolina. It is modeled after the North Carolina Teachers and State Employees Comprehensive Major Medical Plan (State Health Plan) with some additional benefits. The Claims Processing Contractor is Blue Cross/Blue Shield of North Carolina (BCBSNC).The behavioral health benefit is administered by ValueOptions, a national company specializing in this type of care.

2. *How do children enroll?*

Families complete a Health Check/NC Health Choice Application Form which can be obtained from a local department of social services office, by calling the NC Family Health Resource Line at 1-800-367-2229, or by going online to www.ncdhhs.gov/dma/cpccont.htm. (Click on "How do you apply for NCHC?"; then "Health Check/NC Health Choice for Children Application" in English or Spanish. Children who apply for Health Check/NC Health Choice are first screened to determine if they are eligible for Health Check. They are enrolled in Health Check or NC Health Choice based on their age and the income level of the family.

For information about how you can help families enroll, please see Appendix D.

3. *What services are covered under NC Health Choice for Children?*

NC Health Choice for Children is a comprehensive health insurance program covering a range of services for children. These include acute and preventive care services, hospitalization, and special hearing and vision benefits. Prescription drugs are covered. Dental benefits include prophylactic, evaluative and therapeutic services. Benefits for children with special health care needs (CSHCN) are similar to those covered by Health Check (Medicaid). For more details on NC Health Choice covered services refer to the member handbook online at: www.ncdhhs.gov/dma/CHIP/NCHChandbook.pdf .

4. *How will I know that an individual is a member of the NC Health Choice for Children plan?*

Children will have a card identifying them as members of the NC Health Choice for Children Plan.

5. *How long are children enrolled? Will I be reimbursed for services if families fail to re-enroll their children?*

Children are normally enrolled for 12 continuous months. Health Check/Health Choice is not renewed automatically. *Providers should verify eligibility at each visit and remind patients to start the re-enrollment process 2 months prior to the end of their certification period; the re-enrollment packet will arrive in the mail.* If the patient is found to be ineligible, providers will not be reimbursed by Health Choice for services that occur after the original termination date.

To verify the member's enrollment status call: 1-800-422-4658

6. *When a member reaches the maximum age of 19 years old, are they covered through the end of that month?*

Yes

7. ***Does the patient need authorization from the primary care physician to see a mental health provider?***

No. However, the service provided must be part of the covered benefit in order to receive reimbursement. ValueOptions, Inc. must pre-certify[1] all care with the exception of the first 26 unmanaged outpatient visits each fiscal year (July 1 through June 30). For more detail, see information in PRE-CERTIFICATION section of this document or the mental health section of the benefit book online.

8. ***Does the NC Health Choice plan have pre-existing condition waiting periods?***

No.

9. ***What is the administrative link between Medicaid and NC Health Choice for Children?***

The state's Medicaid agency, the Division of Medical Assistance, is responsible for setting eligibility policies, overseeing eligibility determination in county departments of social services and assessing the program performance of NC Health Choice. The State Health Plan/BCBSNC is responsible for the benefit structure and processing and payment of claims for the program. ValueOptions, Inc. is the administrator for the behavioral health benefit and manages this part of the program. The Division of Public Health/Children and Youth Branch is responsible for outreach and marketing efforts to enroll children in the program. This division also oversees the enhanced coverage of Children with Special Health Care Needs (CSHCN) as defined in the legislation.

BECOMING A MENTAL HEALTH PROVIDER UNDER NC HEALTH CHOICE:

10. ***Which mental health, alcohol and drug treatment professionals are qualified to provide care or treatment under NC Health Choice?***

The professionals qualified to provide treatment are listed in the "NC Health Choice Handbook" (the family's benefit booklet). The 2006 edition is available online at**:**
www.ncdhhs.gov/dma/CHIP/NCHChandbook.pdf.

For a list of qualified providers see Appendix A.

11. ***How about provisionally licensed providers? Can they bill for services?***

No.

12. ***If an outpatient mental health provider is qualified, what do they need to do to enroll in NC Health Choice for Children?***

For a qualified outpatient mental health provider (see Appendix A):

- If the provider currently files their claims electronically, then either the BCBSNC Provider # or the NPI # must be used. With full implementation of NPI, only the NPI # will be used.
- If the provider files paper claims, forms should be submitted using the BCBSNC Provider # or the NPI #, if available, and the Federal Tax ID #. If a provider is not enrolled, the Federal Tax ID # is all that is required to file a paper claim. (See Question 20 for further information).

[1] This term is the same as pre-authorize.

13. ***If a mental health provider is employed by a program/facility, do they need to enroll individually?***

No, they do not enroll individually and billing is done by the program/facility.

COVERED MENTAL HEALTH SERVICES

14. ***Are mental health and substance abuse services both covered?***

Yes.

15. ***What specific services are covered?***

Basic benefits include treatment in the following settings: outpatient (offices or clinics), inpatient facilities, residential treatment centers, partial hospitalization programs (PHP), intensive outpatient programs (IOP), and 23 hour crisis stabilization units. (See Q17 for additional benefits/special services).

16. ***Does NC Health Choice cover early intervention behavioral health services such as psychosocial screening and situational crisis intervention?***

Yes, NC Health Choice provides for up to six "early intervention behavioral health" outpatient visits. These are billed as "early intervention visits" and do not require an Axis I psychiatric or chemical dependency diagnosis. Up to two visits may be billed with no diagnosis by using the code 799.90 for assessment. The remainder of the six are then billed with a V-code if there is no Axis I diagnosis.

Refer to Appendix B for details as well as the CPT Codes to use for these services.

17. ***What special services for mental health are covered?***

Special services constitute additional benefits for children with documented medical necessity. Currently these include Community Support, Day Treatment, Residential Services, Intensive In-Home, Multi-Systemic Therapy (MST), Diagnostic Assessment, Mobile Crisis. In addition, Targeted Case Management services are covered as medically necessary for children with developmental disabilities.

For information regarding the criteria for special services and to determine which services may be covered for a particular child, call: 1-800-753-3224.

Or, go to www.valueoptions.com, click on "Providers", then "Network-Specific", then "North Carolina Health Choice" for a full list of services covered for children with special health care needs.

18 ***Is family therapy a covered benefit under NC Health Choice?***

Yes. (See Appendix B for Coding Guidance)

19. ***When behavioral health care providers consult with parents, school-based personnel or other professionals in the community regarding a specific student's health or mental health issues, is this service covered? Can it be billed separately?***

These types of consultations are considered part of the basic service being provided, and therefore are not covered separately.

REIMBURSEMENT AND BILLING

20. ***How is a provider reimbursed for a service?***

Claims are filed with BCBSNC using CPT codes on standard CMS 1500 forms. Approximately 90% of the claims are paid within 30 days. Forms should be submitted using the BlueCross BlueShield NC provider number or NPI, if available, and federal tax identification. If a provider is not enrolled, the federal tax identification number is all that is needed. However, having a BCBSNC provider number facilitates processing the claim.

To obtain a provider number, contact the customer service line at: 1-800-422-4658.

Provider numbers are not issued for practitioners whose main purpose is to provide targeted case management for DD clients, community support services, day treatment, Multi-Systemic Therapy (MST), Mobile Crisis, therapeutic foster care or residential group home services, or diagnostic assessment.

21. ***How much is a provider reimbursed for service?***

As of 7/1/06 the reimbursement rate is 100% of the Medicaid rate. Reimbursement will be made directly to the provider of record.

22. ***If a service is covered, can I bill the NC Health Choice for Children member for the difference between my charges and the BCBSNC reimbursement?***

No, for covered services you cannot bill a NC Health Choice for Children member any amount other than the co-payment, if applicable.

23. ***Can I bill members for services that are not part of the benefits package for NC Health Choice for Children?***

Yes. You can bill members for services that are not a part of the benefits package. The family must be informed that they will be responsible for this bill BEFORE the service is rendered.

24. ***How do I bill for an initial psychiatric evaluation?***

Unless billing for an early intervention behavioral health visit, the provider should use CPT 90801 or 90802 on a CMS 1500 claim form.

25. ***What diagnosis coding system is used to bill for mental health services - DSM IV or ICD-9?***

BCBSNC prefers the ICD-9 code. Both are recognized. Note that behavioral health visits may not be billed under a physical health diagnosis code.

26. ***Is it necessary to administer the Child and Adolescent Functional Assessment Scale (CAFAS) in order to bill for High Risk Intervention?***

Not absolutely. A comparable instrument may be used. ValueOptions requires an assessment, not necessarily the CAFAS.

27. ***What documentation is required when billing for a mental health service?***

Documentation should be done in accordance with professional guidelines (i.e., assessment, treatment plan, progress notes, etc.). Treatment notes must clearly document symptoms, functioning, and progress toward measurable goals and must be made available if requested by the Claims Processing Contractor; otherwise, assessment/treatment/progress notes are not required when billing for a mental health service.

28. ***When would additional documentation be required?***

If a request is to be made for more than 26 visits, the provider completes and submits an ORF2 (Outpatient Request Form 2) to ValueOptions, Inc., prior to the 26th visit.

ValueOptions may request additional information if an appeal is being processed for non-certification.

In addition, BCBSNC, the Claims Processing Contractor, may request additional information within the first 26 visits if there is a question about the appropriateness of payment.

29. ***What should I do if I do not agree with a decision to deny a claim, or if I disagree with the reimbursement provided?***

The same appeals processes that are established for the State Health Plan are also available for NC Health Choice for Children for clinical denial of services. The appeals process for behavioral health services is outlined in each non-certification letter.

For more information call the Appeals Coordinator for Health Choice at:
ValueOptions: 1-800-753-3224

If you are concerned about denial of reimbursement for services that have been approved by NC Health Choice or about the rate of reimbursement for approved services, please contact BCBSNC, the Claims Processing Contractor at 1-800-422-4658.

30. Is it possible to stop an Explanation of Benefits Form (EOB) from being mailed to the parent if the service provided was a confidential service?

No, an EOB is mailed anytime a service is provided and billed to NC Health Choice.

31. If a child comes in for a well child check-up or a primary care visit on the same day that they are seen for an initial psychiatric evaluation or a psychotherapy visit, can both be billed on the same day?

Yes, both the physical health and mental health visits may be billed on the same day. However, the physical health claim must not be filed with a mental health procedure code.

PRECERTIFICATION[2]

Note: **All forms necessary for precertification are available on the ValueOptions website:** www.valueoptions.com; select "Providers"; choose "Network Specific", then choose "North Carolina Health Choice".

32. ***Is precertification needed for all behavioral health care (mental health and substance abuse)?***

Yes, with one exception. Precertification is not necessary for the first 26 outpatient psychotherapy visits during the Plan Year (July 1 through June 30). In addition, Diagnostic Assessment (one per fiscal year is allowed without authorization) and Mobile Crisis (first 8 hours or 32 15-minute units are allowed without authorization). All other services must be precertified prior to the beginning of treatment by submitting the appropriate forms located on the ValueOptions website (www.valueoptions.com; select "Providers"; choose "Network Specific", then choose "North Carolina Health Choice") or by calling 1-800-753-3224

For more detail, see below.

33. ***What should a provider do if treatment is expected to continue beyond 26 visits?***

If treatment is expected to continue beyond 26 visits, providers should request approval from ValueOptions, Inc. prior to the 26th visit. At that time, providers must submit an Outpatient Request Form 2 (ORF 2) which may be obtained from ValueOptions, Inc.

For copies of the form or more information please check the ValueOptions website for the most current requirements and forms or call 1-800-753-3224.

34. ***How are the 26 visits counted?***

The 26 visits include all outpatient "office-visit-type" mental health services the patient receives during the plan year even if rendered by more than one provider (i.e., the 26 visits are combined for early intervention behavioral health, mental health and substance abuse visits across all providers). An exception is made when psychiatric claims are submitted for medication management visits using CPT Code 90862. CPT 90862 is not excluded from the 26-visit count when the claim is being filed with a substance abuse diagnosis.

For example:

- A 30-minute individual therapy session equals one visit toward the 26.
- A 50-minute psychotherapy session equals one visit toward the 26.
- A ½ hour, 1-hour or 1 ½ hour group therapy session counts as one visit toward the 26.
- One psychological testing session counts as one visit.
- The six "early intervention behavioral health" visits count toward the 26 unmanaged visits.

BCBSNC cannot determine how many visits the patient has had. BCBSNC can only report how many claims have processed on a "first received" basis, regardless of when the service was provided. Coordination of CPT billing as well as service provision is important when more than one provider is treating a patient.

[2] Note: This is the same as pre-authorization.

35. ***Does inpatient treatment need to be precertified?***

Yes, inpatient treatment is covered, but precertification is required from ValueOptions, Inc. before the patient is admitted.

The Inpatient Treatment Request (ITR) can be found at www.valueoptions.com; choose "Provider"; choose "Network Specific"; choose "NC Health Choice". Scroll down to "Provider Forms". Fax the completed ITR to 919-379-9035.

36. ***What happens if precertification has not been obtained? Can I bill the member for these services?***

No. If precertification is not obtained before admission, the member may not be billed for the non-precertified services. Nor can the family be billed for services that have been denied based on medical necessity.

37. ***Does psychological testing require precertification?***

Not always. No precertification is required when psychological testing is done within the first 26 unmanaged visits. One outpatient testing session counts as one visit. However, all other psychological testing, including that which is administered while as an inpatient, during partial hospitalization, intensive outpatient program (IOP) or in a residential treatment center (RTC), requires precertification prior to the testing.

For codes see Appendix B. For approval, call 1-800-753-3224.

REIMBURSEMENT FOR HIGHER LEVELS OF CARE

38. ***How are claims filed for higher levels of care – i.e., inpatient, residential treatment centers (RTC), partial hospitalization (PHP), intensive outpatient program (IOP) services, 23-hour stabilization?***

These claims are filed via standard revenue codes on a UB-92 claim form. See Appendix B for specific codes to be used for IOP.

39. ***How do the requirements for residential treatment centers (RTCs) and group homes differ?***

Residential treatment centers are covered when precertified and medically necessary under the basic benefit, which requires state licensure for residential treatment, national accreditation (JCAHO, CARF, COA), 24-hour licensed RN staff and an attending or consulting psychiatrist or addictionologist.

Group homes licensed by the Division of Facility Services are covered when pre-certified and medically necessary under the Special Services benefit. Separate criteria have been developed for making medical necessity decisions for group home and therapeutic foster home admissions for NC Health Choice children.

Therapeutic Foster homes licensed by the Division of Social Services are also covered.

APPENDIX A: QUALIFIED OUTPATIENT MENTAL HEALTH PROVIDERS

- **Licensed psychiatrist (MD) or (DO)**
- **Licensed psychologist (PhD), (EdD) or (PsyD)**
- **Certified clinical social worker (CCSW)**
- **Licensed clinical social worker** (**LCSW**)
- **Licensed professional counselor (LPC)**
- **Licensed marriage and family therapist (LMFT)**
- **Certified fee-based pastoral counselor (PhD)**
- **Licensed psychological associate (LPA)**
- **Licensed physician assistant**; must be supervised **and** employed by a psychiatrist
- **Certified Clinical Specialist in Psychiatric and Mental Health Nursing** (RN, certified by the American Nurses Credentialing Committee which now certifies clinical specialists as Advanced Practice Registered Nurses, Board Certified)
- **Registered nurse (RN) or (RN-C)**; must be supervised and employed by a licensed psychiatrist or licensed psychologist

For alcohol and drug problems only:

- **Certified substance abuse counselor (CSAC)**
- **Licensed clinical addiction specialists (LCAS)**
- **Certified clinical supervisor (CCS)**
- **Physician (MD) or (DO);** licensed as an MD or DO in the state in which services are provided, and be certified by the American Society of Addiction Medicine.

APPENDIX B: FREQUENTLY USED CODES

Initial Psychiatric Diagnostic Interview Examination*

90801
90802
* *Do not* use for early intervention behavioral health visits.

Individual Psychotherapy with Mental Health Diagnosis*

90804 – 90815
* Requires credentialed provider. Group therapy permitted if each group member has Axis I diagnosis with therapy for each member billed by appropriately credentialed provider.

Psychological Testing*

CPT 96101,96116, 96118
* One session which counts as one visit toward the twenty-six unmanaged visits.

Family and Group Psychotherapy

90846 – 90847
90853

Medication Management*

90862
* Does not count toward the twenty-six unmanaged visits unless there is a substance abuse diagnosis.

Intensive In-home Services

H2022
* Does not count toward the twenty-six unmanaged visits;
* Must be precertified by ValueOptions' Clinical Care Manager as medically necessary prior to the start of treatment.

Early Intervention/Risk Reduction Visits*

99401	Individual	15 minutes (counts as 1 visit)
99402	Individual	30 minutes (counts as 1 visit)
99403	Individual	45 minutes (counts as 1 visit)
99404	Individual	60 minutes (counts as 1 visit)
99411	Group	30 minutes (counts as 1 visit)
99412	Group	60 minutes (counts as 1 visit)

* Up to 2 of the 6 visits may be billed using code 799.90 without an Axis I psychiatric or chemical dependency diagnosis, thus allowing 2 visits for assessment purposes. The remainder of these 6 visits must be billed with a V-code if there is no Axis I diagnosis. This means the following combinations of 6 visits may be billed and reimbursed as part of the twenty-six unmanaged visits each plan year:

  1 visit filed as 799.90 / 5 with a V-code
  2 visits filed as 799.90 / 4 with a V-code
  0 visits filed as 799.90 / 6 with a V-code

Treatment in an Intensive Outpatient Program (IOP)*

* This is a structured, multi-modality treatment program and is not the traditional 1:1 office-based psychotherapy or group therapy.

Claims for this service are filed using the revenue codes (listed below) on a UB-92 claim form.

905 – IOP for alcohol abuse or dependence; Chemical abuse or dependency

912 – IOP for psychiatric disorders

APPENDIX C: FREQUENTLY USED PHONE NUMBERS

TO ENROLL AS A PROVIDER	1-800-422-4658 Follow the prompts for NC Health Choice for Children. Ask for the State Health Plan/NC Health Choice Provider Relations Representative.
TO VERIFY ELIGIBLITY	1-800-422-4658 Follow the prompts for NC Health Choice for Children.
FOR PRECERTIFICATION	1-800-753-3224 or FAX: 919 379 9035-
TO ENROLL FAMILIES	1-800-367-2229 North Carolina Family Health Resource Line For more information or to get an application.
TO APPEAL	1-800-753-3224 Ask for the Appeals Coordinator for NC Health Choice.
TO VERIFY CURRENT BENEFIT PACKAGE	1-800-422-4658 Follow the prompts for NC Health Choice for Children.
TO VERIFY CRITERIA FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS	1-800-753-3224 Ask for the Account Representative.
TO INQUIRE ABOUT ELIGIBLE PROVIDERS OF SPECIAL SERVICES	1-800-753-3224 Ask for the Account Representative.

APPENDIX D: FIVE STEPS TO HELP UNINSURED CHILDREN ENROLL IN HEALTH CHECK / NC HEALTH CHOICE

Step 1:

Become familiar with Health Check / NC Health Choice so that you can describe the major features of our state's child health insurance programs to the families you serve.

To learn more about Health Check / NC Health Choice, go online to www.nchealthystart.org. Click on "For the Public" and then "Child Health Insurance." This family-friendly Web site provides information and links to benefits booklets and application forms.

There is also a PowerPoint orientation to Health Check / NC Health Choice at www.nchealthystart.org/outreach/materials/ppt.html .

Step 2:

Order free Health Check / NC Health Choice outreach materials and application forms from the NC Healthy Start Foundation (www.nchealthystart.org) to distribute to families.

To view materials available, click on "Catalog"; then "Health Check (Medicaid) / NC Health Choice Materials." Then click on "Order" to order online.

Step 3:

Tell uninsured families in your practice that Health Check / NC Health Choice may be for them!

Refer interested families to the local Department of Social Services (DSS), to the North Carolina Healthy Start Foundation Web Site (www.nchealthystart.org – "For the Public"), or to the NC Family Health Resource Line:

- 1-800-367-2229 (English and Spanish)
- 1-800-976-1922 (TTY for the hearing Impaired)

The line operates Monday through Friday from 8 a.m. to 5 p.m.

Step 4:

Identify staff in your practice that can help families with the application process.

Training is available through most local DSS agencies.

Step 5:

Become involved in local outreach efforts.

You can find the name of the lead outreach contact in your community by going online to http://www.nchealthystart.org/outreach/index.html. (Click on "County Info" in Right Column; click on "County Name"; click on the live link next to "Health Check Coordinators").